agement of these events in the retail or neighborhood pharmacy as well as between institutions, for insight into differences in communication and coordination.

An interesting area for exploration is the evolving role of the pharmacist within the hospital as the hospital itself becomes a more formal institutional structure and as the manual skills of compounding have vanished. The pharmacist usually has more control over the intake (purchase) of drugs than over the internal flow of drugs within the hospital where the doctor wields far more power. The pharmacist may "catch" the mistakes of doctors but ultimately must refer them to designated foci of authority within the medical staff. The lack of strong institutional support for the pharmacist's authority (especially in large hospitals abounding in pharmacologists and other medical specialists) tends to make him turn to informal means of extending his influence or building up a reserve of influence—such as taking care of staff drug needs, and being a good team member in hospital activities not related to the pharmacy.

There are some sources of conflict in this situation in that patient welfare depends critically on the pharmacist's judgment. In contrast to nursing, where this is also true but only a few patients are so dependent on a single nurse, the population of the entire hospital depends on a few pharmacists in this critical way.

Sources of Drug Information Used by Doctors

In the sequence of events which leads to a decision to prescribe, the receipt of information by doctors is an important stage. Something can be learned from analyzing subscription lists of specific medical journals, government bulletins, and independent bulletins such as the "Medical Letter" even though some journals are less read and less heeded than others.

Efforts have been made in the United Kingdom and in the United States to determine sources of information on drugs used by practitioners.[1,2,4] Analysis could also be made of the informational components and attitudes conveyed by drug advertising—particularly of change over time. In the United States, some advertisers shifted perceptibly after 1959 from pride in innovation to appeal to the "tried and true" qualities of drugs. Establishing a trend in advertising content would take systematic study.

Clinical Trials as a Social Process

Going back even further, one meets the whole process of building a record of successful clinical trials reported in the medical literature as a prerequisite of government approval for marketing a new drug. For those interested in the level of intellectual activity involved in reported clinical research, the review by Laties and Weiss[9] of a number of papers on the use of meprobamate (a tranquilizer) in treatment of anxiety is most illuminating. The review shows great unevenness as to the experimenters' provision for dealing with bias, the technics of measuring response to the drug, and the interpretation of results.

For those concerned with interrelations between conduct of research and the provision of care, published papers on clinical trials show to what extent they are centered at teaching hospitals and thus whether new drugs are introduced into patient care under conditions of approval by medical peers, monitoring for side effects, and sophisticated evaluation of results. Papers on drug research also show how often the trials involve the very sick as against the mildly ill patient (and by implication what decisions about total care have